



## Vaccine Administration Record

Patient Name \_\_\_\_\_

Clinic Name/Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

I have read or have had explained to me, information about the diseases, and the vaccines listed below. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below be given to me or to the person named above (for whom I am authorized to make this request)."

Vaccine	Route	Date Given (m/d/y)	Dosage	Vaccine Manufacturer & Vaccine Lot #	Site	VIS Materials Publ. Date	Initials - Person Administering Vaccine	Signature of Parent or Guardian
Hep B - 1	IM							
Hep B - 2	IM							
Hep B - 3	IM							
DT DTaP - 1	IM							
DT DTaP - 2	IM							
DT DTaP - 3	IM							
DT DTaP - 4	IM							
DT DTaP - 5	IM							
Hib - 1	IM							
Hib - 2	IM							
Hib - 3	IM							
Hib - 4	IM							
Polio - 1	SQ IM							
Polio - 2	SQ IM							
Polio - 3	SQ IM							
Polio - 4	SQ IM							
PCV7 - 1	IM							
PCV7 - 2	IM							
PCV7 - 3	IM							
PCV7 - 4	IM							
MMR - 1	SQ							
MMR - 2	SQ							
Varicella - 1	SQ							
Varicella - 2	SQ							
Hep A - 1	IM							
Hep A - 2	IM							
Influenza	IM							
Influenza	IM							
(for additional see other side)								
Td	IM							
Td	IM							
(for additional see other side)								
Pneum Polysacc	IM							
Other:								

Initials & Signatures of Persons Administering Vaccine:

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Patient Name	<input type="text"/>
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**Initials & Signatures of Persons Administering Vaccine:**